

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25380**

FILED AUG 22 1955

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **881**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give town) St. Joseph		c. LENGTH OF STAY (in this place) 2 Yrs.	c. CITY OR TOWN St. Joseph
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		e. STREET ADDRESS (If rural, give location) 1026 Ridenbaugh St. 0110	
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) H. c. (Last) MELVIN		4. DATE OF DEATH (Month) (Day) (Year) Aug. 15, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 17, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	9. AGE (In years last birthday) 77
11. BIRTHPLACE (City and State or Foreign Country) Viroqua, Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Taylor Melvin		13b. MOTHER'S MAIDEN NAME Jane Silbaugh	14. NAME OF HUSBAND OR WIFE Elizabeth Melvin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 499-16-4191	17. INFORMANT'S SIGNATURE OR NAME Mr. & Mrs. Walter Milliken ADDRESS St. Jos. Mo
18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia Congestive heart failure ANTECEDENT CAUSES DUE TO (b) (2) Arteriosclerotic heart disease DUE TO (c) Diabetes mellitus, duodenal ulcer, renal anemia,	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4200	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) DR Stallard at the clinic saw on 8-14 at 8:00 AM	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-12 , 1955, to 8-15 , 1955, that I last saw the deceased alive on 8-13 , 1955, and that death occurred at 3:40 AM , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W. C. [Signature] M.D.		23b. ADDRESS 502 Edmund, City	23c. DATE SIGNED 8-15-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug 18/55	24c. NAME OF CEMETERY OR CREMATORY Morris Chapel Ceme. Bethany, Mo.	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. Aug 18, 1955	REGISTRAR'S SIGNATURE Kathleen M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE Barry Funeral Home ADDRESS St. Joseph	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RES! 9 100

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Emma Clark*.....

Licensed Embalmer No. *42*

P. O. Address *St. J. ...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.